

Complete Summary

GUIDELINE TITLE

Surgical management of traumatic parenchymal lesions.

BIBLIOGRAPHIC SOURCE(S)

Bullock MR, Chesnut R, Ghajar J, Gordon D, Hartl R, Newell DW, Servadei F, Walters BC, Wilberger J, Surgical Management of Traumatic Brain Injury Author Group. Surgical management of traumatic parenchymal lesions. Neurosurgery 2006 Mar; 58(3 Suppl): S2-25-S2-46. [73 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Traumatic parenchymal lesions including:

- Focal lesions (intracerebral hematomas (ICH), delayed traumatic intracerebral hematomas (DTICH), contusions, infarctions)
- Nonfocal lesions (cerebral edema, hemispheric swelling and diffuse injury).

GUIDELINE CATEGORY

Management
 Treatment

CLINICAL SPECIALTY

Emergency Medicine
Neurological Surgery
Neurology

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To determine appropriate surgical indications, methods and timing for the patient with traumatic parenchymal injuries

TARGET POPULATION

Patients with traumatic parenchymal injuries

INTERVENTIONS AND PRACTICES CONSIDERED

1. Computed tomography (CT) scan
2. Glasgow Coma Scale score
3. Intracranial pressure monitoring
4. Neurological monitoring
5. Operative interventions
 - Craniotomy with evacuation of mass lesion
 - Bifrontal decompressive craniectomy
 - Decompressive procedures (including subtemporal decompression, temporal lobectomy, and hemispheric decompressive craniectomy)
6. Nonsurgical management

MAJOR OUTCOMES CONSIDERED

- Glasgow outcome score
- Mortality rate
- Level of disability/functional recovery

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A MEDLINE computer search using the following key words: "intracerebral" or "intraparenchymal" or "ICH" or "IPH and "hematoma" or "hematoma" or "hemorrhage" and "surgery" or "craniotomy" or "craniectomy" or "burr hole" or "craniostomy" and "trauma" or "traumatic" or "TBI" or "CHI" between 1975 and

2001 and limited to humans was performed. A total of 330 documents were found. An additional search using the following key words: "brain" or "cortex" and "laceration" between 1975 and 2001 was performed, yielding 101 additional articles. This search was narrowed to include the following key words: "surgery" or "operative" or "craniotomy" or "craniectomy" or "decompressive craniectomy" or "repair" and "outcome," yielding 49 articles. A third search using the following key words: "contusion" or "hemorrhagic contusion" and "brain" and "surgery" or "craniotomy" or "craniectomy" or "burr hole" or "craniostomy" was performed, yielding 174 articles. A fourth search, using the key words "DTICH" or "DTIPH," yielded 11 articles. A fifth search, using the key word "TICH," yielded eight articles. All five searches were combined. Duplicates between searches were discarded. A total of 495 references resulted. In addition, the reference lists of selected articles were reviewed, and a total of 51 articles were selected for critical analysis. The results of this analysis were incorporated into the review presented here. Papers primarily addressing the following topics were not included: nontraumatic lesions (e.g., spontaneous intraparenchymal hemorrhage or infarction), patients with other associated nontraumatic lesions (e.g., tumors or arteriovenous malformations), posttraumatic aneurysms, chronic lesions, penetrating trauma, carotid-cavernous fistulae, patients undergoing anticoagulation therapy, patients with associated illnesses (e.g., acquired immunodeficiency syndrome; concomitant infection; hemophilia; thrombotic thrombocytopenic purpura; or hemolysis, elevated liver enzymes, and low platelet count), pregnant patients, birth trauma, traumatic intraventricular hemorrhage, traumatic hydrocephalus, external ventricular drainage, sagittal sinus injury, pre-CT era reports, and book chapters. Papers with the following characteristics were also excluded: case series with fewer than 10 patients evaluated by CT scan and with incomplete outcome data (mortality or Glasgow outcome score [GOS]), case reports, operative series with operations occurring greater than 14 days from injury. Posterior fossa parenchymal injuries are addressed in Surgical Management of Posterior Fossa Mass Lesions. Selected articles were evaluated for design, prognostic significance, therapeutic efficacy, and overall outcome. In addition, several articles were reviewed for the purposes of historical perspective.

NUMBER OF SOURCE DOCUMENTS

51

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Classification of Evidence

When assessing the value of therapies or interventions, the available data was classified into one of the following three categories according to the following criteria:

Class I: Evidence from one or more well-designed, randomized, controlled clinical trials, including overviews of such trials

Class II: Evidence from one or more well-designed comparative clinical studies, such as nonrandomized cohort studies, case-control studies, and other comparable studies

Class III: Evidence from case series, comparative studies with historical controls, case reports, and expert opinion

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Evaluation and Weighting of the Evidence

The journal articles found have been carefully read and evaluated, including an assessment of the methodology used in the studies. This not only includes the establishment of the clinical question addressed (e.g., therapeutic effectiveness, diagnostic tests, prognostic studies, etc.) and type of study (randomized controlled trial, case-control study, case series, etc.), but also the quality of the study with respect to potential errors in design, execution, or conclusions reached. Therefore, studies that might, on the surface, represent evidence supporting one level of recommendation, may instead be flawed enough to be devalued to support a recommendation of lesser strength. The quality of the literature was evaluated in this way according to well-established criteria. All articles were cross-reviewed and disagreements were resolved by consensus.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Link Between Evidence and Guidelines

The general concept of relating strength of recommendations to strength of evidence reflecting varying degrees of clinical certainty was formalized into a scheme that has been followed by medical societies, including organized neurosurgery, from the inception of the Guideline development process. Despite problems with the strict application of this paradigm (some of which are displayed and discussed in this supplement), the scheme has the benefit of using scientific evidence rather than expert opinion for the substrate of the recommendations, although expert opinion is used to formulate the recommendations themselves, as well as to make judgments regarding the quality of the evidence. The evidence-based scheme used in these and all Guidelines regarding therapeutic effectiveness endorsed by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons begins with classification of the literature into three categories of evidence (see "Rating Scheme for the Strength of the Evidence" above).

The classification of evidence into these three categories leads to the formulation of recommendations called Standards, Guidelines, and Options. Class I evidence is used to support treatment recommendations of the strongest type, practice Standards, reflecting a high degree of clinical certainty. Class II evidence is used to support Guidelines, reflecting a moderate degree of clinical certainty. Class III evidence supports practice Options reflecting unclear clinical certainty. This terminology was developed to indicate, in normal vocabulary, the strength of the recommendations on the basis of strong to weak medical evidence. In neurosurgery, this scheme has been used to formulate Guidelines, rather than a scheme that uses letters or numbers that have no grounding in language and are, therefore, more easily misinterpreted. The link between scientific evidence and recommendations has been highlighted in these Guidelines by presenting those studies in the scientific foundation that support the stated recommendation in boldface type.

Expert Judgment and Empirical Evidence

There are two ways in which expert judgment comes into Guideline development. The most common use of expert opinion is in developing recommendations for practice. This has been a usual method in the past (as well as the present, in the form of textbook chapters), but has more recently given way to more formalized approaches embraced by evidence-based medicine methodology, such as that used in this supplement. However, even in evidence-based methodology, expert opinion is used to evaluate the literature as well as to frame the concepts and wording of the recommendations. In addition, if the evidence is weak and conflicting, expert opinion is used to derive recommendations. This use is unavoidable, but the expert opinion is guided by the evidence published in the literature, rather than from personal experience alone.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Levels of Recommendations

Standards: Represent accepted principles of patient management that reflect a high degree of clinical certainty.

Guidelines: Represent a particular strategy or range of management strategies that reflect a moderate degree of clinical certainty.

Options: Are the remaining strategies for patient management for which there is unclear clinical certainty.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

In all Guidelines published under the auspices of the Brain Trauma Foundation and the American Association of Neurological Surgeons, other professional organizations were involved in either developing the Guidelines or reviewed and approved them. In these Surgical Management of Traumatic Brain Injury Guidelines, however, only neurosurgeons were involved. These neurosurgeons represent a wide range of organizations. There were representatives from the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, the European Brain Injury Consortium, the American College of Surgeons (Committee of Trauma) and the World Federation of Neurological Surgeons (Neurotrauma section) involved in the development of these Surgical Management of Traumatic Brain Injury Guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

"Degrees of Certainty" [Standards, Guidelines, Options] and "Classification of Evidence" [Class I to III] are defined at the end of the "Major Recommendations" field.

Note: All of the following recommendations are at the Options level, supported only by Class III scientific evidence.

Recommendations

Indications

- Patients with parenchymal mass lesions and signs of progressive neurological deterioration referable to the lesion, medically refractory intracranial hypertension, or signs of mass effect on computed tomographic (CT) scan should be treated operatively.
- Patients with Glasgow Coma Scale (GCS) scores of 6 to 8 with frontal or temporal contusions greater than 20 cm³ in volume with midline shift of at least 5 mm and/or cisternal compression on CT scan, and patients with any lesion greater than 50 cm³ in volume should be treated operatively.
- Patients with parenchymal mass lesions who do not show evidence for neurological compromise, have controlled intracranial pressure (ICP), and no significant signs of mass effect on CT scan may be managed nonoperatively with intensive monitoring and serial imaging.

Timing and Methods

- Craniotomy with evacuation of mass lesion is recommended for those patients with focal lesions and the surgical indications listed above, under Indications.
- Bifrontal decompressive craniectomy within 48 hours of injury is a treatment option for patients with diffuse, medically refractory posttraumatic cerebral edema and resultant intracranial hypertension.
- Decompressive procedures, including subtemporal decompression, temporal lobectomy, and hemispheric decompressive craniectomy, are treatment

options for patients with refractory intracranial hypertension and diffuse parenchymal injury with clinical and radiographic evidence for impending transtentorial herniation.

Summary

The majority of studies regarding surgical treatment of parenchymal lesions are case series. Only one prospective clinical trial of treatment using surgical versus nonsurgical management has been published. The majority of evidence indicates that the development of parenchymal mass lesions, which are associated with progressive neurological dysfunction, medically refractory intracranial hypertension, or radiological signs of mass effect, are associated with a poor outcome if treated nonsurgically. Specific surgical criteria, however, have not been firmly established.

Evidence also suggests that decompressive craniectomy may be the procedure of choice in patients with posttraumatic edema, hemispheric swelling, or diffuse injury, given the appropriate clinical context. This context has yet to be defined.

Definitions:

Degrees of Certainty

Standards: Represent accepted principles of patient management that reflect a high degree of clinical certainty.

Guidelines: Represent a particular strategy or range of management strategies that reflect a moderate degree of clinical certainty.

Options: Are the remaining strategies for patient management for which there is unclear clinical certainty.

Classification of Evidence on Therapeutic Effectiveness

Class I: Evidence from one or more well-designed, randomized, controlled clinical trials, including overviews of such trials

Class II: Evidence from one or more well-designed comparative clinical studies, such as nonrandomized cohort studies, case-control studies, and other comparable studies

Class III: Evidence from case series, comparative studies with historical controls, case reports, and expert opinion

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are all at the Option level, supported only by Class III scientific evidence (e.g., evidence from case series, comparative studies with historical controls, case reports, and expert opinion)

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate surgical management of traumatic parenchymal lesions to improve clinical outcomes and reduce morbidity and mortality

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

As in all other areas of evidence-based medicine, these Guidelines have been formulated strictly in accordance with externally imposed constraints. Only clinical human-based literature has been reviewed. Only literature from 1975 through 2001 has been reviewed. Mainly literature in English, with far fewer articles in other languages, was reviewed. For these reasons, the reader must clearly understand that the scope and level of magnitude of the recommendations made here are distilled from the available literature and interpreted according to the rules of evidence-based medicine.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Bullock MR, Chesnut R, Ghajar J, Gordon D, Hartl R, Newell DW, Servadei F, Walters BC, Wilberger J, Surgical Management of Traumatic Brain Injury Author Group. Surgical management of traumatic parenchymal lesions. Neurosurgery 2006 Mar; 58(3 Suppl): S2-25-S2-46. [73 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Mar

GUIDELINE DEVELOPER(S)

Brain Trauma Foundation - Disease Specific Society

SOURCE(S) OF FUNDING

Brain Trauma Foundation
Integra NeuroSciences

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

Congress of Neurological Surgeons - Professional Association

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format from the [Brain Trauma Foundation Web site](#).

Print copies: Available from Jamshid Ghajar, MD, PhD, Brain Trauma Foundation, 708 Third Avenue, Suite 1810, New York, NY 10017, Email: ghajar@braintrauma.org

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Introduction. Neurosurgery 2006 Mar; 58(3 Suppl): S2-1-S2-3.
- Methodology. Neurosurgery 2006 Mar; 58(3 Suppl): S2-4-S2-6.

Electronic copies: Available in Portable Document Format (PDF) from the [Brain Trauma Foundation Web site](#).

Print copies: Available from Jamshid Ghajar, MD, PhD, Brain Trauma Foundation, 708 Third Avenue, Suite 1810, New York, NY 10017, Email: ghajar@braintrauma.org

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 15, 2006. The information was verified by the guideline developer on August 18, 2006.

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